

CRP was increased in 75.3%. A cardiac MRI was performed in 90.5% of cases and a coronary angiography in 47.6% of cases. No endomyocardial biopsy was performed. An infectious aetiology was found in 47.6% of cases. Treatment included aspirin (87.5%), beta-blockers (66.5%), and ACE inhibitors (42.9%). There was no death during hospital stay. At a mean follow-up of 28 ± 20 months, 2 Pts (2.6%) died from non-cardiac causes and recurrences occurred in only 5.3% of Pts. Mean ejection fraction was $62.1 \pm 5.3\%$.

Conclusion Patients admitted in a cardiology intensive care unit for acute myocarditis are mostly young males and a large part of admissions occurs during winter. In-hospital and mid-term outcome is good.

The author hereby declares no conflict of interest

0358

Incidence and predictors of major haemorrhagic complications in pulmonary embolism patients receiving thrombolytic therapy

Blandine Aupy (1), Gérard Pacouret (1), Fabrice Ivanès (2), Raphaël Philippart (2), Christophe Saint Etienne (1), Dominique Babuty (3), Laurent Fauchier (3), Denis Angoulvant* (3)

(1) CHU Tours, Hôpital Trousseau, Chambray les Tours, France –

(2) Université F. Rabelais, EA 4245 'Cellules Dendritiques et Greffes', Tours, France – (3) CHU Tours-Université F. Rabelais, Tours, France

*Corresponding author: d.angoulvant@chu-tours.fr (Denis Angoulvant)

Thrombolytic therapy (TT) has a beneficial risk to benefit ratio for patients presenting with massive pulmonary embolism (PE). The PEITHO study suggested that patients with sub massive PE may improve their hemodynamic status and prognosis after TT but with an excess of haemorrhagic complications (HC). Elderly patients are also more likely to experience severe HC and it has been suggested that half doses TT may be indicated in this population. TT indication remains questionable in these borderline patients.

To investigate incidence and predictors of major HC in our population we performed a retrospective analysis of all PE patients treated with TT in the Cardiac Intensive Care Unit of our university hospital from 1992 to 2014.

From February 1992 to December 2014, 293 PE patients received TT. Among them 35 experienced severe HC following the PEITHO study definition. 23 (8%) patients died during the acute phase, 7 from HC and 16 from haemodynamic complications.

Although before 1996 TT was frequently administered in sub massive PE and elderly patients we didn't observed a significantly higher rate of severe HC in the 1992-1996 period. Bleeders were not significantly older than non-bleeders (72 vs 67, $p=0.09$) and were more likely to receive alteplase as TT ($p=0.045$). Severe HC were significantly more frequent in patients presenting with syncope (37% vs 15%, $p=0.0064$) or shock (66% vs 36%, $p=0.0006$). Patients with severe HC had a significantly higher death rate during hospitalisation (23% vs 6%, $p=0.0005$). From our observational data we derived the HACASSP score that robustly predicts severe haemorrhagic complications in our population combining hypertension, age > 75, cancer, anemia, shock, sex, platelet count (C statistic = 0.73).

Our analysis suggests that it may be possible to predict high risk of severe haemorrhagic complications of TT in PE patients and therefore to improve the risk to benefit ratio of TT especially in patients with sub massive PE at presentation.

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0101

Medical telephone triage of emergency calls for thoracic pain: construction of a score for acute coronary syndrome prediction. DOREMI 2 study

Sandrine Charpentier* (1), Catherine Pradeau (2), Samantha Huo Yung Kai (3), Arnaud Bourdè (4), Didier Carrié (1), Vanina Bongard (1), Vanessa Houze Cerfon (5), Jean-Louis Ducassé (5)

(1) CHU Toulouse, Rangueil, Toulouse, France – (2) SAMU 33, Bordeaux, France – (3) CHU Toulouse, Toulouse, France – (4) SAMU 974, Saint Denis de La Réunion, La Réunion – (5) CHU Toulouse, Purpan, Toulouse, France

*Corresponding author: charpentier.s@chu-toulouse.fr (Sandrine Charpentier)

Background Identification of the coronary origin of a thoracic pain by the emergency physician in charge of telephone triage at the pre-hospital emergency service is a key element of prognosis.

Purpose To build a gender-specific telephone score for predicting ACS for patients calling for non-traumatic thoracic pain.

Method Observational multicenter prospective study. Patients ≥ 18 years old calling the telephone triage center for a non-traumatic chest pain were included. The outcome was ACS diagnosis estimated by two independent experts. Separate models were built for men and women. Multivariable analyses were carried out to identify predictive items of ACS using a stepwise logistic regression. Models performances were assessed (c-statistic). Data were randomly divided into a derivation and a validation sample.

Results In three medical centers, 3727 patients were included (2097 men, 1630 women). ACS were diagnosed in 24.2% of men and 8.5% of women. Among men, variables independently associated with ACS were age, smoking, pain intensity, persistence of pain, retrosternal pain, lack of increased intensity with inspiration, pain irradiations, pain association to other signs. The area under the receiver operator characteristic (ROC) curve (AUC) was 0.76 (95% confidence interval (CI) 0.73-0.79). A 48 point score was built. The AUC of the score applied to the validation sample was 0.77 (95% CI 0.73-0.80). Among women, variables independently associated with ACS were age, previous coronary artery disease, lack of increased pain intensity with inspiration, pain irradiations. The AUC was 0.79 (0.75-0.83). A 23 point score was built. The AUC of the score applied to the validation sample was 0.67 (95% CI 0.60-0.74).

Conclusion Predictive characteristics of ACS in patients who call medical dispatch centre for chest pain are different for women and men. The predictive accuracy of the models we developed was better among men than women.

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0291

Incremental value of copeptin with high sensitivity cardiac T troponin for exclusion of severe coronary stenosis in patients with preexisting coronary artery disease

Anais Iemmi*, Anne-Marie Dupuy, Nils Kuster, Jean-Paul Cristol, Francois Roubille, Jean-Christophe Macia, Benoît Lattuca, Mariama Akodad, David Belardi, Florence Leclercq
CHU Montpellier, Montpellier, France

*Corresponding author: anais_iemmi@hotmail.fr (Anais Iemmi)

Background Acute chest pains without troponin raise are challenging in patients with pre-existing coronary artery disease (CAD).

Purpose To evaluate the diagnostic and incremental prognostic values of copeptin in patients with normal high sensitivity troponin T (hs-cTnT) value, pre-existing CAD and acute chest pain.

Methods This monocentric prospective study included 91 consecutive patients with documented CAD admitted in the intensive care units for chest pain lasting for less than ten hours. Acute coronary syndrome (ACS) was excluded with ECG and hs-cTnT values $< 14 \text{ ng/L}$ at baseline and with dynamic changes $\leq 50\%$ three hours later and $< 20\%$ if baseline hs-cTnT between 14 and 50 ng/L (Roche Diagnostics, COBAS 8000). The hs-cTnT assay was validated with the upper reference limit (99th percentile) of 14 ng/L and limit of detection at 5 ng/L . Blood samples for determination of copeptin (ThermoFisher, Kryptor Compact) were collected at presentation. Copeptin value was considered as positive when $> 10 \text{ pmol/L}$ (detection limit at 2 pmol/L). Prognosis evaluation concerned absence of severe stenosis ($> 90\%$) or fractional flow reserve > 0.80 at coronary angiography, or absence of myocardial ischemia induced with nuclear stress imaging.

Results Mean age of patients was 58 ± 8.72 (79.3%) were male. The mean time between chest pain onset and blood samples was 4 ± 2 hours. According to clinical decision, coronary angiography was performed in 63 patients (69.2%), with 12 severe stenosis diagnosed (19%). No ischemia was detected with the stress tests (28 patients). Among the 52 patients with a negative

Abstract 0291 – Table: Predictive values

	Sensitivity	Specificity	Positive predictive value	Negative predictive value
hs-cTnT <14 ng/L and <50% change at 3 hours n=91	0.22 IC (0.028-0.6)	0.73 IC(0.604-0.83)	0.10 IC(0.012-0.317)	0.87 IC (0.755-0.947)
Copeptin <10 pmol/L + hs-cTnT <14 ng/L n=71	0.75 IC(0.428-0.945)	0.6 IC (0.476-0.715)	0.24 IC(0.118-0.412)	0.93 IC(0.817-0.986)
Copeptin<10 pmol/L + negative kinetic of hs-cTnT at 3 hours n=52	0.79 IC (0.4-0.972)	0.54 IC (0.418-0.669)	0.19 IC (0.08-0.352)	0.95 IC (0.823-0.994)

kinetic of hs-cTnT and a negative copeptin, only 2 (3.8%) had a critical stenosis (NPV 95%) both related to in stent restenosis (table 1).

Conclusion In patients with pre-existing CAD, once ACS is excluded, copeptin provides a useful additional triage strategy in acute chest pain to exclude severe coronary stenosis or stenosis inducing myocardial ischemia.

The author hereby declares no conflict of interest

0358**Diuretic treatment versus fluid expansion in acute normotensive pulmonary embolism**

Elie Dan Schouver, Olivier Chiche, Priscille Bouvier, Julien Tomi, Pamela Mocerri, Pierre Cerboni, Emile Ferrari
CHU Pasteur, Cardiologie, Nice, France

Background In submassive pulmonary embolism (PE), when a right ventricular (RV) dysfunction (RVD) is present, the benefit of fluid expansion (FE) is questionable. The Frank-Starling law suggests that the reduction of the RV overload may enhance the RV systolic function.

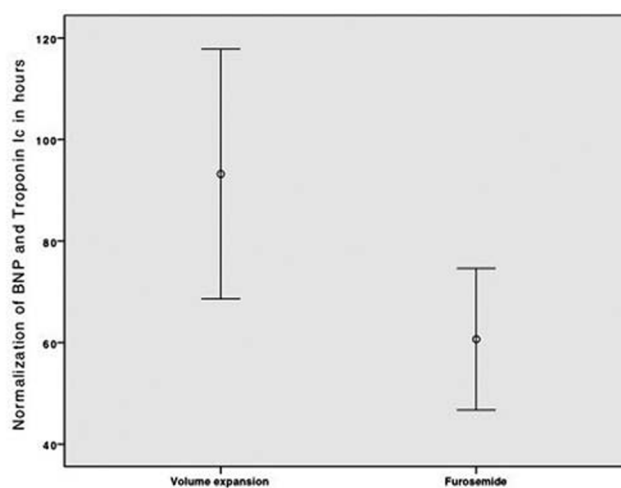
Purpose The aim of our study was to compare the effects of a diuretic treatment (DT) versus FE in patients hospitalized for normotensive PE with RVD.

Methods We performed a prospective study. Consecutive patients hospitalized for normotensive PE were treated with diuretic (40mg IV furosemide at admission) or FE (500cc of sodium chloride infusion during four hours at admission). The primary endpoint was the timing for normalization of BNP and troponin Ic values. The secondary endpoints were variations of clinical and RV echographic parameters.

Results Forty five patients were included. Timing for Troponin and BNP normalization was 60,7±28 hours in the DT versus 93,2±42 hours in the FE

group (figure 1, p=0.02). Normalization of RV dilatation took 91,7±14,2 hours in the DT group versus 108,4±17,5 hours in the FE group (p=0.01). Normalization of the RVD took 81,2±18 hours in the DT group versus 94,9±13,1 hours in the FE group (p=0.03).

Conclusion In the early management of normotensive PE with RVD, DT may be superior to FE in order to improve the time to normalization of biological and echocardiographic markers.



Abstract 0358 – Figure 1

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